DEPARTMENT OF HUMAN SERVICES

Amendments to Chapters 17-1705, 17-1736, 17-1737, 17-1739.1, and 17-1740.1

Hawaii Administrative Rules

1. Section 17-1705-1, Hawaii Administrative Rules, is amended to read as follows:

"§17-1705-1 Purpose. The purpose of this chapter is to establish the requirements for applicants and recipients of medical assistance. Applicants and recipients shall:

(1) Assign their rights to third party payments and medical support;

(2) Cooperate in obtaining third party payments for medical assistance, pursuing any third party who may be liable for medical support, and obtaining child support; and

(3) Be required to satisfy all conditions set forth by the third party to receive coverage, to the extent coverage is available through that third party, before Medicaid reimbursement is allowed."

[Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§433.138, 433.145, 433.146, 433.147; 45 C.F.R. §§232.11, 232.12)

2. Section 17-1705-38, Hawaii Administrative Rules, is amended to read as follows:

"§17-1705-38 Medical payment involving third party. (a) The liability of a third party shall be treated as a resource applicable to the cost of needed medical services when:

(1) It has been verified that a legal obligation actually exists; and

(2) The amount of the obligation may be determined within thirty days from the time of the recipient's need for medical care.

(b) No Medicaid payment shall be made under a refund plan for that portion of cost for which a third party has been determined to be liable and reimbursement is forthcoming.

(c) If a liability by an identified third party exists, the recipient shall be required to satisfy all conditions set forth by that third party to receive coverage, to the extent coverage is available through that third party, before Medicaid payment is allowed.

[(c)] (d) When the existence or extent of third party liability is in question, medical assistance payments may be made in:

(1) Part, if the recipient has excess income and other assets; or

(2) Whole, if the recipient accepts, in writing, an assignment of the recipient's third party payment to refund the department.

However, when third party policy prohibits assignment of payment, the recipient, in writing, shall agree to refund the department or health plan upon being paid.

[(d)] (e) After a claim is paid or medical services are rendered, if the department or health plan learns of the existence of a liable third party, the department or health plan shall seek reimbursement from the third party within thirty days after the end of the month it learned of the existence of the liable third party.

[(e)] (f) The department or health plan shall suspend or terminate an effort to seek reimbursement from a liable third party if it determines that the effort would not be cost effective because the amount it reasonably expects to recover will be less than the cost of recovery.

[(f)] (g) The department or health plan shall accumulate billings with respect to a liable third party when making a decision whether to seek recovery. When the accumulated amount is $500 or more, the department or health plan shall seek recovery."

[Eff 08/01/94; am 11/25/96; am] (Auth: HRS §§346-14, 346-37) (Imp: HRS §346-37; 42 C.F.R. §433.139)

3. Section 17-1736-15, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1736-15 Requirements for participation in the program by providers. ***

(b) An individual, institution, or organization shall meet all of the following requirements in order to become and retain eligibility as a provider under the medical assistance program:

(1) The provider shall be licensed or approved as follows:

(A) The provider, if an individual, shall be licensed to practice the provider's profession in accord with state law. Permits, temporary licenses, provisional licenses, expired or unrenewed licenses, or any form of license or permit which requires supervision of the licensee shall not serve to qualify the licensee as an approved provider of service under the Hawaii medical assistance program;

(B) The provider, if a medical or health related institution, shall be certified by the state department of health under applicable public health rules of the state and standards of the federal government. The following shall apply regarding Medicare certification for participation in Medicaid:

(i) Hospitals are required to be Medicare certified;

(ii) Facilities that provide SNF services are required to be Medicare certified;

(iii) Facilities that provide SNF and ICF services, but are not Medicare certified, may participate as an ICF; and

(iv) Facilities that provide ICF services only are unable to obtain Medicare certification, therefore, participation as an ICF is allowed.

(C) The provider of any other health care services shall comply with standards and all licensure, certification and other requirements as applicable;

(2) The provider shall comply with the

non-discrimination provisions of Title VI of the Civil Rights Act of l964 (42 U.S.C. §2000d) by not discriminating against program beneficiaries on the basis of race, color, national origin, or mental or physical handicap; and

(3) The provider shall accept [medicaid's] Medicaid's established rates of payments whether based on DHS's fee schedule, negotiated rate, reasonable cost reimbursement, or other adopted rates, whichever is applicable, as payment in full for goods, care, or services furnished. The provider shall not require any participation in payment by the [medicaid] Medicaid recipient for goods, care, or services furnished by the provider. The provider shall not demand or receive any additional payment from any [medicaid] Medicaid recipient with the exception of the department's proviso for cost sharing of medical care costs." [Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: HRS §346-59; 42 C.F.R. §§440.40, 442.12, 442.101, 447.15, 482.1, 483.1; Pub. L. No. 100-360 §301)

4. Section 17-1737-2, Hawaii Administrative Rules, is amended by adding the definitions of "national accreditation organization" and "qualified mental health professionals" to read as follows"

"§17-1737-2 Definitions. ***

"National accreditation organization" means, but is not limited to, the following national accreditation organizations for community mental health rehabilitative services:

(1) The Council on Accreditation (COA);

(2) The Commission on Accreditation of Rehabilitation Facilities (CARF); or

(3) The Joint Committee on Accreditation of Healthcare Organizations or (JCAHO).

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"Qualified mental health professionals" or "QMHP"

means:

(1) A psychiatrist licensed to practice medicine in the State of Hawaii in accordance with chapter 453, HRS, and who is certified or is eligible to be certified in psychiatry by the American Board of Psychiatry or Neurology;

(2) A psychologist licensed in accordance with chapter 465, HRS;

(3) A licensed clinical social worker in behavioral health licensed in accordance with chapter 467E, HRS;

(4) An advance practice registered nurse (APRN) licensed in accordance with chapter 457, HRS; or

(5) Any other person as determined by the department of human services."

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[Eff 08/01/94; am 01/29/96; am 07/06/99; am ; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 U.S.C. §1396r(8)(d)(4) and (5))

5. Chapter 17-1737, Hawaii Administrative Rules, is amended by adding a new section 17-1737-44.1 to read as follows:

"§17-1737-44.1 Community mental health rehabilitative services. (a) Medical payments to eligible providers may be made for the following types of community mental health rehabilitative services:

(1) Crisis management: This service provides mobile assessment for individuals in active state of crisis (twenty-four hours per day, seven days a week). Immediate response is required. Crisis management services include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting, such as the

home, school, work environment, or other community setting as well as in a health care setting. These services are provided through agencies accredited by a national accreditation organization. These agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff shall be supervised at a minimum by a qualified mental health professional.

(2) Crisis Residential Services: Crisis Residential Services are short-term interventions provided to individuals experiencing crisis, to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital-based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are:

(A) Psychiatric medical assessment;

(B) Crisis stabilization and intervention;

(C) Medication management and monitoring;

(D) Individual, group or family counseling or all if necessary; and

(E) Daily living skills training.

Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs shall have less than sixteen beds. The services do not include payment for room and board. Staff providing crisis residential services shall be qualified mental health professionals.

If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

(3) Biopsychosocial Rehabilitative Programs: This is a therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs. Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. A plan of care must identify the treatment goals and the scope, amount and duration of services that will assist the individual to achieve the goals. A plan of care must be approved by a licensed physician, licensed psychologist, advanced practice registered nurse or licensed clinical social worker in behavioral health. Plans of care must be reviewed and approved every ninety calendar days. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum, the plan of care must:

(A) Define the goals and objectives for the individual;

(B) Educate the individual about his or her mental illness;

(C) How to avoid complications and relapse; and

(D) Provide opportunities for him or her to learn basic living skills and improve interpersonal skills.

Services are provided by qualified mental health professionals or staff that are under

the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization.

(4) Intensive Family Intervention: These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbances or adults with serious mental illness. These services:

(A) Diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;

(B) Assess and monitor the service needs of the identified individual so that he or she can be safely maintained in the family;

(C) Ensure the clinical appropriateness of services provided; and

(D) Improve the individual's ability to care for self and the family's capacity to care for the individual.

This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of

qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff shall be supervised at a minimum by a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization.

(5) Therapeutic Living Supports and Therapeutic Foster Care Supports: These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for three to six individuals, but not more than fifteen individuals, per home. Therapeutic foster homes provide services for a maximum of fifteen individuals per home. Although these group living arrangements and therapeutic foster homes may provide twenty-four hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training, directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health

professionals. Services shall be provided in a licensed facility and provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with twenty-four hour on-call coverage by a licensed psychiatrist or psychologist.

(6) Intensive outpatient hospital services: These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child shall meet at least two of the following criteria:

(A) Is at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition;

(B) Exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, or the police; or

(C) Are unable to recognize personal danger, inappropriate social behavior, or recognize and control behavior that presents a danger to others.

The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering

intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least twenty hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization. Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologists must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed hospital certified by a national accreditation organization or other licensed facility that is Medicare certified for coverage of partial hospitalization/day treatment. These services are not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

(7) Assertive Community Treatment (ACT): This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria:

(A) At high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition;

(B) Exhibits inappropriate behavior that

generates repeated encounters with mental health professionals, educational and social agencies, or the police; or

(C) Is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others.

The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his or her maximum functional level. Treatment interventions include:

(A) Crisis management (crisis assessment, intervention and stabilization);

(B) Individual restorative interventions for the development of interpersonal, community coping and independent living skills;

(C) Services to assist the individual develop symptom monitoring and management skills;

(D) Medication prescription, administration and monitoring medication and self medication; and

(E) Treatment for substance abuse or other co-occurring disorders.

Services include twenty-four hours a day, seven days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff shall

be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization. Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopyschosocial rehabilitation as a separate service is not allowed.

(b) Community mental health rehabilitative services are available to individuals eligible for medical assistance and who are medically determined to need mental health, drug abuse, or alcohol services or all three. These services must be recommended by a licensed physician, licensed psychologist, advanced practice registered nurse or a licensed clinical social worker in behavioral health to promote the maximum reduction or restoration, or both, of a recipient to their best possible functional level relevant to their diagnosis of mental illness, abuse of drugs or alcohol.

(c) Individuals who are mentally retarded (MR) or developmentally disabled are not eligible for these services, including mentally retarded and developmentally disabled individuals who are in Home and Community Based Waiver programs.

(d) Community mental health rehabilitative services shall be provided by the agencies certified by the department of Health, adult mental health division and child and adolescent mental health division.

(e) The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a licensed psychiatrist or psychologist. Services must be medically necessary.

(f) The statewide reimbursement rate shall be the rate negotiated by the department. The final rate will be based on the following factors:

(1) Cost to provide the service;

(2) Comparison to comparable Medicaid provider types;

(3) Relative value to other services within the established fee schedule;

(4) Rate will not exceed Medicare's upper limit of reimbursement; and

(5) Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability.

(g) Reimbursement shall be based of the following units of service:

(1) Per contact (Crisis management services);

(2) Daily (crisis residential, therapeutic support, intensive outpatient hospital services), or

(3) Fifteen minute increments (assertive community treatment (ACT), biopsychosocial rehabilitative programs and intensive family intervention)." [Eff] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.130)

5. Chapter 17-1737, Hawaii Administrative Rules, is amended by adding a new section 17-1737-51.1 to read as follows:

"§17-1737-51.1 Telehealth services. (a) Telehealth services is the use of communication equipment to link health care practitioners and patients in different locations. It may be used in place of a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. For purposes of this section, the term "patient" refers to individuals eligible for medical assistance.

(b) Telehealth services may be provided to patients only if they are presented from an originating site located in either a:

(1) Rural Health Professional Shortage Area (HPSA) as defined by section 332(a)(1)(A) of the Public Health Service Act;

(2) In a county outside of a Metropolitan Statistical Area, as defined by Section 1886(d)(2)(D) of the Social Security Act; or

(3) From an entity that participates in a Federal telemedicine demonstration project that has been approved by the Secretary of Health and Human Services as of December 31, 2000.

(c) Interactive audio and video telecommunication systems must be used. Interactive telecommunications systems must be multi-media communications that, at a minimum, include audio and video equipment, permitting real-time consultation among the patient, consulting practitioner, and referring practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the requirements of interactive telecommunications system. As a condition of payment, the patient must be present and participating in the telehealth visit.

(d) An originating site is the location of a patient at the time the service being furnished via a telecommunications system occurs. Originating sites authorized to furnish telehealth services are listed below:

(1) The office of a physician or practitioner;

(2) A hospital;

(3) A critical access hospital;

(4) A rural health clinic; and

(5) A federally qualified health center. An exception to this provision is an entity participating in a Federal telehealth demonstration project that is approved by or is receiving funding from the Secretary of Health and Human Services as of December 31, 2000. An entity participating in a Federal telehealth demonstration project qualifies

as an originating site regardless of geographic location.

(e) A distant site is the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

(f) Coverage of telehealth services is based on Medicare's criteria. Each provider must bill the appropriate CPT procedure code with the modifier code "TM" indicating the services were provided via telehealth. Only providers eligible to participate in the medical assistance program will be reimbursed for telehealth services. Reimbursements to an originating site and distant site are based on the Hawaii Medicaid fee schedule." [Eff] (Auth: HRS §346-59) (Imp: 42 C.F.R. §410.78; Pub. L. 105-33)

6. Section 17-1737-82, Hawaii Administrative Rules, is amended to read as follows:

"§17-1737-82 Intra-state transportation. (a) Transportation may be provided in order to enable a recipient to secure needed medical care and related services.

(b) Transportation shall be by the most economical means which would not be hazardous or injurious to the recipient's health.

(c) Air transportation may be allowable where the attending physician or a hospital refers a recipient to a specialist or medical facility for diagnostic and treatment services not available or not accessible on the recipient's island of residence. Air transportation requests may be initiated by the department's social worker when a physician is not available to refer an individual for medical care in Honolulu.

(d) In emergency situations, air transportation:

(1) Shall be by regularly scheduled commercial flight when:

(A) Available;

(B) Medical care will not be affected if travel is delayed until the next scheduled flight; and

(C) The patient can sit in a standard seat and requires no oxygen or other life support mechanisms enroute; or

(D) If the patient is unable to sit and a stretcher is required, the airline may accommodate the patient in lieu of four passenger seats;

(2) Shall be by air ambulance service when:

(A) Regularly scheduled commercial flights are inappropriate because of problems with the recipient's condition, which include:

(i) Head injuries with evidence of increasing intracranial pressure;

(ii) Multiple system injuries;

(iii) Complications of labor or prematurity of newborn children with respiratory distress; or

(iv) Other acute injuries or illnesses beyond local capabilities; and do not allow for service or time delays; or

(B) Recipients to be transported on an arranged basis cannot travel by regularly scheduled commercial flights because the recipients are:

(i) In spica casts returning home to another island; or

(ii) Long-term care patients who are bed-bound and going to another island;

(3) If by air ambulance:

(A) Shall be authorized for a one-way trip only; and

(B) Shall have life support services and at least one attendant on the flight;

(4) Shall be arranged by the recipient's attending physician or hospital who shall complete and sign the appropriate form justifying the use of an air ambulance and give the original and all copies of the form to the air ambulance crew chief; and

(5) May be coordinated with surface ambulance service by the referring physician to the designated hospital on the island of destination.

(e) In a non-emergency situation, air transportation:

(1) Shall be subject to prior review and authorization by the department's medical consultant;

(2) May be provided in the form of a round-trip ticket when medical services on another island are recommended by the attending physician and the recipient is expected to return home in two weeks or less;

(3) May be provided in the form of a round-trip ticket to a person accompanying the recipient if an attendant's service is recommended by the commercial carrier. Payment may be made for an attendant's services when rendered by a person other than a relative under section 17-1739-7; and

(4) Shall be by regularly scheduled commercial flights.

(f) In both emergency and non-emergency situations, the department shall allow other related inter-island travel expenses, such as:

(1) Cost of outside meals and lodging, while receiving necessary and authorized medical services; and

(2) Vendor payments for meals and lodging made only to designated providers of the services who have been authorized to participate under the department's medical assistance program.

(g) Ground ambulance service may be allowed as follows:

(1) Emergency ambulance service for injuries shall be available in each county to the patient. Ambulance service may be used in an emergency; and

(2) Ambulance transfer service for transporting a recipient to, from, and between medical facilities and other providers may be utilized when recommended by the attending physician.

(h) Taxi service may be allowed as follows:

(1) Transportation by taxi may be authorized by the payment worker to assist a recipient to obtain covered medical services where:

(A) A recipient resides in an area not served by a bus system;

(B) A recipient has no means of transportation;

(C) Transportation is available but the recipient cannot be accommodated at a suitable hour; or

(D) A recipient is acutely ill, injured or has a physical or mental impairment verified by a physician, and travel by bus would be either hazardous to that person's health or would cause physical hardship; and

(2) For rural areas, available taxi service nearest to the recipient's home shall be utilized.

(3) The department shall not be required to provide transportation beyond the closest geographic area where appropriate health care services are readily available.

(i) Handicab services may be used for recipients who are confined to a wheelchair or who are physically unable to take care of themselves.

(j) Transportation services shall be available for those individuals eligible for medical assistance, provided all the provisions in this section are met. An individual who utilizes benefits for other than their intended purpose, may be referred for potential prosecution of fraud. A provider who knowingly and willfully falsifies, misrepresents, conceals, or fails to disclose material facts to obtain transportation services for an individual, may be referred by the department to the Medicaid fraud control agency or unit for investigation and potential prosecution of fraud. The department may seek the recovery of monies associated with the fraudulent act." [Eff 08/01/94; am 02/10/97; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§ 431.53, 440.170)

7. Section 17-1737-83, Hawaii Administrative Rules, is amended to read as follows:

"§17-1737-83 Out-of-state transportation. (a) Out-of-state transportation may be provided to eligible recipients for covered medical services which are unavailable in Hawaii and with prior authorization by the department's medical consultant.

(b) Transportation shall be by the most economical means which would not be hazardous or injurious to the recipient's health.

(c) Transportation shall be limited to a United States medical facility which is licensed to provide such services and certified as a medicaid provider by the state where the facility is located.

(d) Request for out-of-state transportation shall be made by the attending physician or a medical facility and shall include:

(1) All information requested in the department designated forms; and

(2) A comprehensive clinical summary of the patient's condition, need for out-of-state medical facility service, the name and address of the out-of-state facility and the name and telephone number of the authorized representative of that medical facility.

(e) Out-of-state transportation may be provided in the form of a round trip ticket issued to:

(1) The recipient when the recipient is expected to return home in thirty days or less as determined by the attending physician or medical facility. A one-way ticket may be issued when the recipient is expected to remain out-of-state for more than thirty days.

(2) Any person accompanying the recipient without regard to the person's relationship to the recipient, if an attendant is required by the transportation carrier or recommended by the attending physician or the medical facility and authorized by the department's medical consultant.

(f) Other related travel expenses may be allowed with prior authorization by the department's medical consultant and may include but not be limited to:

(1) Cost of meals and lodging for the recipient and one attendant;

(3) Taxi or other non-emergency ground transportation when such transportation is related to the provision of authorized medical coverage; and

(3) Services of an attendant provided the attendant is unrelated to the recipient.

(g) Transportation services shall be available for those individuals eligible for medical assistance, provided all the provisions in this section are met. An individual who utilizes benefits for other than their intended purpose, may be referred for potential prosecution of fraud. A provider who knowingly and

willfully falsifies, misrepresents, conceals, or fails to disclose material facts to obtain transportation services for an individual, may be referred by the department to the Medicaid fraud control agency or unit for investigation and potential prosecution of fraud. The department may seek the recovery of monies associated with the fraudulent act." [Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§431.53, 440.170)

8. Section 17-1737-107, Hawaii Administrative Rules, is amended to read as follows:

"§17-1737-107 Payment for hospice care. (a) Payments shall be available to [medicaid] Medicaid [certified] providers [for] certified by Medicare to render hospice care as provided for under this subchapter.

(b) Payment for hospice care shall be made [in the same amounts and] using the same methodology as [the medicare] Medicare [program.] and in the amounts specified by CMS.

(c) Payment for services or items not related to the terminal illness and billed by other Medicaid non-hospice providers are allowed.

(d) For a Medicaid recipient who resides in a nursing facility and meets the nursing facility level of care requirements, but elects hospice, the Medicaid program will pay the hospice provider:

(1) For routine hospice services; and

(2) Ninety-five percent of the facility specific per diem rate for ICF services. The Medicaid program shall not pay the NF.

[(c)] (e) The following categories shall be utilized to determine payment:

(1) Routine home care day. A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care as defined in paragraph (2);

(2) Continuous home care day. A continuous home care day is a day on which an individual who has elected to receive hospice care is not

in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished during periods of crisis and only as necessary to maintain the terminally ill patient at home. A minimum of eight hours of care shall be required to qualify for the continuous home care rate;

(3) Inpatient respite care day. An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. Respite care may not be reimbursed for more than five consecutive days at a time; and

(4) General inpatient care day. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings."

[Eff 08/01/94; am] (Auth: HRS §§346-14, 346-59) (Imp: 42 U.S.C. §1396(a) and (d); HRS §346-59)

9. Section 17-1739.1-3, Hawaii Administrative Rules, is amended to read as follows:

"§17-1739.1-3 Controlling factors for payment. (a) The department shall pay for the cost of medical care when the department's medical consultants determine medical care to be necessary to the eligible patient's well-being and medical care is provided, under standards generally acceptable to the medical community, by a practitioner approved by the department to participate in Medicaid.

(b) The department shall not increase the payment made to any provider to offset uncollected amounts for

deductibles, coinsurance, copayments, or similar charges.

(c) No payment shall be made where program rules are violated, or when services furnished are inappropriate to the patient's health care management as determined by the department's medical consultant.

(d) Rates of payment to providers of medical care who are individual practitioners shall be based upon the Hawaii Medicaid fee schedule. The amount paid shall not exceed the maximum permitted to be paid to individual practitioners or other individuals under federal Medicaid laws and regulations, the Medicare fee schedule applicable in the year the service was rendered, the state limits as provided in the appropriation act, the provider’s billed amount, or the rate set by the department.

(e) Rates of payment to out-of-state providers of medical care who are individual practitioners shall be the Medicaid rate paid in the practitioner's state, subject to the conditions of section 17-1736-13. In the absence of a Medicaid payment rate, payment will be according to the Hawaii Medicaid fee schedule.

(f) Payments may be prepaid to health maintenance organizations which the department contracts to provide medical care to eligible public assistance recipients.

(g) The department may withhold payment of claims to recoup overpayments, or may withhold payment pending completion of an audit or investigation.

(1) Payment of pending or future claims may be withheld in an amount reasonably calculated to approximate the amounts of past overpayments.

(2) Payment of pending claims may be withheld until completion of a pending audit or investigation, at which time the department may initiate actions to recoup the amounts of any overpayments discovered.

(3) The department shall notify the provider in writing of its intent to withhold payments and shall include reasons for the proposed action, the effective date of the action, and a statement of the provider's right to request administrative review of the proposed action.

(4) The effective date of withholding shall be

sixteen calendar days following the issuance of the notice.

(h) [Payments for QMB recipients are limited to premiums, deductibles, and coinsurance under Part A and Part B of Medicare.] For a Medicaid recipient with Medicare coverage, payment on a Medicare covered service shall be the applicable Medicare deductible and coinsurance amounts.

(i) For a Medicaid recipient with Medicare coverage, payment on a service that is not covered by Medicare, but is covered by Medicaid, shall be up to the Medicaid rate.

(j) Payment on a QMB claim shall be the applicable Medicare deductible and coinsurance amounts." [Eff 10/26/01; am 04/11/03 ; am] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.10, 447.15, 447.57, 447.200)

10. Section 17-1739.1-14, Hawaii Administrative Rules, is amended as follows:

"§17-1739.1-14 Medical payment involving third party liability. (a) The liability of a third party for the cost of the medical services shall be treated as a resource applicable to the cost of needed medical services when:

(1) It has been verified that a legal obligation actually exists; and

(2) The amount of the obligation may be determined within thirty days from the time of the recipient's need for medical care.

(b) No Medicaid payment may be made under a refund plan for that portion of cost for which a third party has been determined to be liable and reimbursement is forthcoming. An exception is Medicaid's agreement with Medicare on durable medical equipment processing.

(c) If a liability by an identified third party exists, the recipient shall be required to satisfy all conditions set forth by that third party to receive third party coverage, to the extent coverage is available, before Medicaid payment is allowed.

(d) When the existence or extent of third party liability is in question, medical assistance payments may be made:

(1) In part, if the recipient has excess income and other assets; or

(2) For the entire cost of the medical services, if the recipient assigns to the department in writing, the third party payment; provided that where third party policy prohibits assignment of payment, the recipient shall, in writing, agree to refund the department upon being paid by the third party." [Eff 10/26/01; am] (Auth: 0HRS §346-59) (Imp: 42 C.F.R. §§433.135 through 433.154, 447.20)

11. Section 17-1740.1-2, Hawaii Administrative Rules, is amended by adding the definitions of "Medicare principles of reimbursement", "provider agreement", and "visit".

"§17-1740.1-2 Definitions. ***

"Medicare principles of reimbursement" means that body of accounting, cost finding, cost allocation, and cost limit principles that has developed over time in the administration of the Medicare program under Title XVIII of the Social Security Act. It includes, without limitation, the principles identified in the following authorities:

(1) The Social Security Act, 42 U.S.C. §§1395 et seq.;

(2) The regulations promulgated pursuant to that Act, including 42 C.F.R. Part 413;

(3) Manuals published by the Health Care Financing Administration, including HCFA Pub. No. 15; and

(4) Intermediary letters and bulletins disseminated by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS).

***

"Provider agreement" means the contract between the department and the FQHC or RHC for the delivery of covered items and services to eligible recipients.

***

"Visit" means a face-to-face encounter between an eligible recipient who is a patient of the FQHC or RHC and either:

(1) A health care professional; or

(2) Another person who delivers health care services incident to the health care professional's practice; and

(3) The visit results in the eligible recipient receiving a covered item or service.

Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment."

[Eff ; am] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

12. Chapter 17-1740.1, is amended by adding a new section 17-1740.1-18, Hawaii Administrative Rules, to read as follows:

"§17-1740.1-18 Billing. (a) Each FQHC or RHC shall complete and submit to the department's fiscal agent the appropriate claim form for any covered item or service, regardless of whether a claims-based interim payment will result.

(b) The claims shall either be on forms provided by the department or in a format that the department has indicated in advance is acceptable."

[Eff ; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

13. Chapter 17-1740.1, is amended by adding a new section 17-1740.1-19, Hawaii Administrative Rules, to read as follows:

"§17-1740.1-19 Provider agreement. Each FQHC or RHC shall execute a provider agreement with the department." [Eff ; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: Pub. L. No. 106-554)

14. Materials, except source notes, to be repealed are bracketed. New material is underscored.

15. Additions to update source notes to reflect these amendments are not underscored.

16. These amendments to Chapters 17-1705, 17-1736, 17-1737, 17-1739.1 and 17-1740.1, Hawaii Administrative Rules, shall take effect ten days after the filing with the Office of the Lieutenant Governor.